Medicare Prescription Drug, Improvement, and Modernization Act of 2003

Medicare Drug Benefit: Drugs Priced Through Competition, Not Government Price Setting

Section 101

How Are Prescription Drug Prices Determined for the New Medicare Drug Benefit?

- Prices for drugs under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are based on competitive forces -- not government price setting. Private plans will negotiate directly with manufacturers and others to get the lowest possible prices for drugs. Plans that fail to obtain competitive prices will not be able to offer attractive premiums to beneficiaries, and will lose market share to plans that are more adept at this type of price negotiation.

- Indeed, the federal government is prohibited from interfering with the negotiations between the plans and manufacturers under the law. This "noninterference" provision in the law prohibits the Secretary of Health and Human Services (HHS) from:

  - Interfering with drug price negotiations among plans, drug manufacturers and pharmacies;
  - Setting drug prices directly; or,
  - Mandating a specific formulary for the Medicare program.

- The "noninterference" provision has had bipartisan support in previous bills:

  - Stark: Motion to Recommit on HR 4680, (*Congressional Record*, June 28, 2000). 203 Democrats voted in favor of the motion (which failed)

  - Daschle-Reed, S.2541, May 10, 2000 (33 Democratic co-sponsors)

  - Wyden, S. 1185 ("SPICE Act"), July 17, 2001

  - Eshoo-Frost, HR 4607 (16 Democratic co-sponsors)

  - Jeffords, Breaux, Landrieu, Tripartisan bill (S.2729/S.2)

Repeal of the "noninterference" provision is not necessary and would be risky:

- **Non-Interference Can Cut Two Ways.** Many are arguing that Medicare should use its clout to get better prices. In the past, Medicare's enormous size and single payer approach has too frequently made it very vulnerable to pressure to raise payments.

- **HHS would not be able to negotiate further reductions in prices**
  The non-partisan Congressional Budget Office (CBO) estimates that striking the non-interference provision would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree. Because they will be at substantial financial risk, private plans will have strong incentives to negotiate price discounts, both to control their own costs in providing the drug benefit and to attract enrollees with low premiums and cost-sharing requirements.

- **The private organizations that have successfully conducted drug price negotiations for employer-sponsored insurance will do it for Medicare, too.**
  The law requires that private plans wishing to offer a Medicare drug plan must provide Medicare beneficiaries with access to negotiated prices. These prices must take into account discounts, subsidies, and direct or indirect remunerations. Organizations such as PBMs and insurers have significant experience negotiating prices, and performing the other functions required under the law. Indeed, PBMs are the national standard for the administration of drug benefits. Over 200 million Americans have their drug benefits managed by a PBM, including many seniors (primarily those with employer-sponsored insurance coverage).

  PBMs manage costs by negotiating with manufacturers and pharmacies to secure price concessions, and maintaining a highly automated claims processing environment. A January 2003 GAO Report (*Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies, January 2003)*, examined the effectiveness of using PBMs by three health plans that account for 55 percent of FEHBP enrollment. The GAO found that average price obtained by PBMs for 14 selected brand name drugs was 18 percent below the average price paid for by cash-paying customers. For 4 selected generic drugs, PBMs obtained prices 47 percent below the prices paid by cash paying customers. Mail order programs obtained prices significantly lower. PBMs were successful in lowering the cost of pharmaceutical benefits primarily by:

  - Securing manufacturer rebates and passing the rebates on to plans,
  - Negotiating reduced prices with pharmacies,
  - Using mail order pharmacy, and
  - Using various utilization management techniques common in the industry.

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- **We should not repeat our prior mistakes. Medicare and Medicaid's drug price setting experience has not been positive**. Medicare has overpaid for Part B drugs for years, not only wasting taxpayer dollars but also inflating beneficiary co-payments. The Medicare Prescription Drug, Improvement, and Modernization Act finally makes significant changes to the way Medicare pays for these drugs that will help correct this situation. And, Medicaid's "best price" requirement has distorted the market for other payers and may discourage manufacturers from offering lower prices. According to GAO and CBO[1], manufacturers are not willing to give discounts of a magnitude that would increase their rebate obligations to Medicaid. The new law permits manufacturers to offer lower prices for Medicare beneficiaries without triggering rebate concerns, and we believe that this will lead to some prices that are lower than they otherwise would be.

- **Competition among private plans to secure favorable drug pricing has been a successful model for other government programs, including FEHBP**. FEHBP leaves price negotiations up to the private plans that provide coverage for federal retirees. It has worked well for these plans, and we believe it will for Medicare as well.

- **Price setting by a program as large as Medicare could be disruptive to the health care market.** Medicare beneficiaries account for about 40 percent of the dollars spent on prescription drugs in the U.S. If Medicare undertakes a heavy-handed government approach to drug prices, the potential implications for the market are large. While some government programs (including those managed by the Veterans Administration and the Public Health Service) have had some success with mandated pricing, these programs are much smaller than Medicare, and their pricing strategies do not have as great an impact on the health care market. VA and DoD payments for prescription drugs account for less than 1 percent of spending for prescription drugs in the United States (2001). Price setting by a program as large as Medicare may not permit adequate investment in research and development that we need for the future.

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[1] GAO: *Prescription Drugs: Expanding Access to Federal; Prices Could Cause other Price Changes.* August 2000. CBO Papers: *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry*. January 1996.